Report to the Legislature

Annual Report: Epidemic Disease Preparedness and Response for Long-Term Care Facilities

December 2022
RCW 70.01.070

Jointly prepared by:

Washington State Department of Social and Health Services (DSHS)

Washington State Department of Health (DOH)

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For more information or additional copies of this report:

Amy Abbott
Residential Care Services
Washington State Department of Social and Health Services
360.725.2489
amy.abbott@dshs.wa.gov

Carolyn Ham
Office of Communicable Disease Epidemiology
Washington State Department of Health
360.878.7906
carolyn.ham@doh.wa.gov

Umair Shah, MD, MPH
Secretary of Health

Jilma Meneses,
Secretary, Department of Social and Health Services

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Executive Summary

On May 3, 2021, the Legislature adopted Substitute House Bill 1218, Chapter 159, Laws of 2021, to improve the health, safety, and quality of life for residents and clients in certified and licensed long-term care (LTC) settings. This legislation requires the Department of Health (DOH) and the Department of Social and Health Services (DSHS), with input from key partners, to develop a joint report and guidelines on epidemic disease preparedness and response for those LTC settings. We submitted an interim report to the Legislature in January 2022, and the final report and guidelines in August 2022.

DOH and DSHS developed the interim and final reports following extensive conversations with interested and affected parties in the form of facilitated large group meetings, small group discussions, individual interviews, and surveys. The interim report focused on the specific issues certified and licensed LTC settings in Washington state faced during the COVID-19 pandemic and identified associated needs as SHB 1218 required. It considered visitation policies, admission and discharge policies, access to personal protective equipment (PPE), resident well-being, resident cohorting and treatment, and contact tracing. The final report built on information gathered from all parties and needs discussed in the interim report. It addressed the relationship between state guidelines and federal requirements, instances when guidance issued by different entities may conflict, and work underway to ensure the consistent application of emergency preparedness guidelines in LTC across Washington state.

The annual report brings forward needs the workgroup discussed during the interim report. We address emerging epidemics of public health concern. Currently, monkeypox virus (MPV), is of concern in Washington state. Poliovirus reached national awareness after the State of New York declared a state of emergency due to an outbreak. We also revised the Epidemic Preparedness and Response Guidelines based on the Governor's plain talk guidelines.

Background

On May 3, 2021, the Legislature adopted Substitute House Bill 1218, Chapter 159, Laws of 2021, (SHB 1218) to improve the health, safety, and quality of life for residents in certified and licensed long-term care (LTC) settings. Section 30 of SHB 1218, codified as RCW 70.01.070, requires the Washington State Department of Health (DOH) and the Washington State Department of Social and Health Services (DSHS) to jointly develop a report and guidelines on epidemic disease preparedness and response for long-term care facilities, with input and consultation from interested and affected parties, including but not limited to:

- Local health jurisdictions;
- Advocates for consumers of long-term care;
- Associations representing LTC facility providers; and
- The office of the state long-term care ombuds.

RCW 70.01.070 directs us to develop a report and guidelines on the following timeline:

- Submit a draft report and guidelines on COVID-19 to the healthcare committees of the Legislature by Dec. 1, 2021.
- Submit a final report and guidelines on COVID-19 to the Legislature by July 1, 2022.
- Beginning Dec. 1, 2022, and annually thereafter, review the report and any corresponding guidelines to make necessary changes and add information about any emerging epidemic of public health concern.

The draft report, final report, and annual updates are on the DOH Healthcare-Associated Infection's About Us webpage. This report is the first annual review and update of the epidemic disease preparedness and response report and guidelines.

Methodology

DOH and DSHS convened a workgroup with representatives from advocacy organizations, professional associations, health care coalitions, local health jurisdictions (LHJs), the state long-term care ombuds, state government, long-term care consumers, and other interested parties. The group held six virtual meetings from July through September 2021 to share experiences and lessons learned during the COVID-19 pandemic. To gather more information, we conducted individual interviews and small group discussions with workgroup participants. The workgroup reconvened in early 2022, to collaborate on the guidelines and address other responsibilities listed in RCW 70.01.070. We used these discussions to develop the reports and guidelines.

Workgroup participants actively engaged in the process. Finding lessons learned, however, was less clear-cut than expected. COVID-19 poses significant challenges with frequent, new variants followed by new waves of infections. Identifying lessons learned from COVID-19 will be an ongoing process as the pandemic and associated response evolve.

Public Health System

Washington has a decentralized governmental public health system characterized by local control and partnerships. State law gives primary responsibility for the health and safety of Washingtonians to 35 local health jurisdictions (LHJs) that represent Washington's 39 counties. Each county legislative authority sets up a local board of health that "shall have supervision over all matters pertaining to the preservation of the life and health of the people within its jurisdiction."[1] Elected officials and non-elected members of the public make-up each board of health. Local boards of health approve the budgets, programs, and policies of local public health agencies.

Long-Term Care System

Washington's LTC system is a complex system designed to enable vulnerable adults and medically fragile children to meet their physical, mental, and social needs, goals, and preferences. The Legislature declared residents in LTC facilities "should have a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible."[2] LTC settings include a variety of facility-based and home-based services. DSHS and the Centers for Medicare and Medicaid Services are the primary regulators for LTC facilities. For the purposes of the epidemic preparedness report and guidelines, LTC facilities means:

- Licensed skilled nursing facilities.
- Assisted living facilities.
- Adult family homes.
- Enhanced services facilities.
- Certified community residential services and supports.
- Registered continuing care retirement communities.

Identified Needs

In 2020 and 2021, we gathered and organized comments from workgroup participants. We looked for future best practices and lessons learned associated with each focus area in RCW 70.01.070. We also discussed some overarching needs with participants. You can find the original discussion of lessons learned and identified needs in the January 2022 interim report. The annual report highlights ongoing needs related to epidemic preparedness and the LTC system.

[1] RCW 70.05.060.
[2] RCW 70.129.005.

Education

A need for education across the public health and LTC systems came up often when talking about guidance conflicts and communication challenges. Workgroup participants noted cross-system education at state, local, and business levels may improve development, issuance, and implementation of public health guidance. Examples of cross-system education needs:

- LHJs need to understand the complexities of the LTC system to effectively issue guidance and provide support to LTC operators within their jurisdiction.
- LTC operators need training on how emergency guidance is issued and who to contact when resolving guidance conflicts.
- State leadership involved in the development of emergency guidance needs to understand the major players in the LTC system and know who should be involved in decision making early in a public health emergency.
- Information about the Continuing Care Retirement Community (CCRC) model and how LTC guidance may only apply to portions of a CCRC campus.

Section 19 of SHB 1218, codified as RCW 70.129.185, requires DSHS, DOH, the LTC ombuds, and representatives of LTC facilities to work together to develop training materials for LHJs. We see this as a chance to make materials that can improve any public health system leader 's knowledge of Washington's LTC system. DSHS recently hired a staff member to coordinate work on the section 19 training materials that begins in October of 2022. Table 1 outlines a possible communication and implementation timeline. The training materials are a collaborative effort, and as work begins in earnest, the timeline may shift to meet the development team's needs.

Table 1: Timeline and Process for Communication and Implementation of Section 19 Training Materials

Implementation Step	Action Items	Timeline
Development of training materials	DSHS and DOH will work with the state office of the long-term care ombuds and representatives of long-term care facilities to develop training materials to educate the leadership and staff of local health jurisdictions on the state's long-term care system. These training materials will provide information to assist local health jurisdiction personnel when establishing and enforcing public health measures in long-term care facilities and nursing homes, including: (1) All applicable state and federal resident rights, including the due process rights of residents; and (2) The process for local	Beginning in October 2022

	health jurisdiction personnel to report abuse and neglect in facilities and nursing homes, including during periods when visitation may be limited.	
Review and Feedback on Training Materials	DOH and DSHS will provide an opportunity for local health jurisdiction partners to review and give feedback on materials Using feedback from LHJ partners, DOH and DSHS will make edits. We will share any edits with the long-term care ombuds and representatives of long-term care facilities to receive their feedback.	April-June 2023
Training Rollout	DSHS and DOH will provide information about the training materials and introduce local health jurisdictions to the materials through presentations, emails, and other outreach.	Beginning July 2023

We also will offer training on the epidemic preparedness guidelines created because of RCW 70.01.070. You can find the guidelines on the DSHS Aging and Long-Term Support Administration page and the DOH website will link to them. Training on the guidelines will include information about the public health system and how to access preparedness resources. Table 2 outlines the section 30 communication and implementation timeline.

Table 2: Timeline and Process for Communication and Implementation of Section 30 Guidelines

Implementation Step	**Action Items**	**Timeline**
Communication and Promotion of Guidelines	DSHS and DOH will promote the guidelines through regular communication channels, including Dear Provider letters, GovDelivery email listservs, and regularly scheduled calls with partners. DSHS and DOH will ask long-term care associations to promote the guidelines to their membership. DSHS and DOH will ask long-term care Ombuds to share the guidelines with resident councils within facilities.	Upon submission of the guidelines to the Legislature
Training and Education	DOH and DSHS will offer training on implementation of the guidelines to the LTC community via webinar.	Beginning one month after we submit the guidelines to the Legislature and annually

	Training will include suggestions for implementation at various facility types. Suggestions will be grounded in the reality of staff capacity and the availability of resources. DOH and DSHS will develop supplemental materials to help facilities in implementation based on reported needs.	following the regularly scheduled updates to the guidelines. Note: Due to hiring and onboarding, this step is delayed.
Feedback Collection	DSHS and DOH will collect feedback from facilities that implement the guidelines early to look for opportunities for revision or enhancement.	Beginning 90 days after delivery of the training webinar
Report and Guidelines Review and Revision	DSHS and DOH will stand up workgroups as needed to revise the guidelines; and supply more information and context specific examples for different provider and facility types.	Beginning December 2022 and continuing annually

Staffing

COVID-19 made worse the staffing shortages LTC facilities already faced. It is not uncommon for LTC staff to work across multiple Supported Living agencies and LTC facilities. Existing staffing challenges and stop-gaps, like floating between facilities, supplied COVID-19 with an opportunity to spread quickly through the LTC system. This led to a feedback loop that further destabilized the workforce.

Staffing shortages create ripple effects across LTC facilities and hospital systems. Hospital systems, facing their own staffing shortages, transfer patients to LTC settings as quickly as is appropriate. But some LTC facilities cannot admit new residents due to staffing shortages, even if beds are available. These delays create hospital backlogs, taking hospital beds away from others who may need them.

The LTC system needs a stable workforce. Workgroup participants identified the following needs related to staffing:

- Continued funding they indicated is critical for keeping staff and improving wages.
- More support to give rest and time off to staff, and to fill in the gaps left by staffing shortages.
- A mechanism to trace staff across multiple agencies for contact tracing purposes.
- Behavioral health support to help staff with resilience and recovery.

Workgroup participants reported programs like the Rapid Response Crisis Staffing teams deployed by DSHS have been extremely helpful throughout the pandemic.

Resource Needs

Workgroup participants discussed multiple needs related to resources. A theme of "We weren't ready" quickly arose. Early on and unexpectedly, the pandemic affected access to goods through a sudden demand increase and supply chain problems. LTC facilities have differing experience with emergency preparedness and planning. And many LTC providers learned what resources their facility would need for an infectious disease like COVID-19 during the pandemic. We organized resource needs into three categories: goods, services, and planning.

Goods

- Protections against price gouging. Washington is one of 14 states without legislation expressly prohibiting price gouging during an emergency.
- Early access to governmental supply and an easy process to get supply. Participants said having access to county- and state-level emergency PPE supplies earlier and in greater quantity will be essential in future crises. They recommend creating a streamlined process to access state stocks of PPE, because the process varied by county and was not always intuitive.
- Creative options for smaller LTC providers to access goods. Smaller providers, like adult family homes, do not have access to the bulk suppliers used by hospitals and LTC facilities. Participants recommend developing creative solutions alongside regulatory solutions. For example, coordinated bulk purchases divided among participating LTC providers.
- Rapid distribution of testing resources. For future epidemic planning, workgroup participants noted producing and distributing rapid tests as quickly as possible will be critical to early outbreak identification.

Services

- Dedicated COVID-19 units and transitional care units are an ongoing need and will remain critical as the pandemic continues.
- Ongoing access to the rapid-response staffing teams provided by DSHS. These teams filled a critical gap.
- Designating interpreters, including deaf and ASL interpreters, as essential personnel to ensure all residents receive communications.
- Behavioral health support for residents and staff who survived the COVID-19 pandemic and are displaying symptoms of adjustment difficulties (comparable to Post Traumatic Stress Disorder-PTSD) or other anxiety/depression disorders.

Planning

- Funding for emergency and epidemic preparedness. LTC facilities incur costs when training staff, testing the plan, and evaluating the plan on a regular basis.
- More information about the external organizations available as resources for the preparedness process. Workgroup participants commented it would be helpful to have a repository of preparedness plans they could adapt to their individual LTC organization.
- Decision-making tools. A "decision tree" may make it easier for providers to make admission and discharge decisions during an outbreak. Participants suggested this tool might alleviate confusion, especially when guidance changes rapidly.
- LTC residents and family members need public health guidance plain talked. People with intellectual and developmental disabilities need easy read versions. Specifically, materials that explain guidance their specific facility is following and how that guidance affects the delivery of care and services.

The interim report gives an overview of funding streams in the LTC system, including COVID-19 specific relief funds. Enhanced Federal Medical Assistance Percentages (FMAP) funds temporarily changed the split of Medicaid funding from the typical 50/50 between state and federal dollars (with some variations among programs) to a higher amount of federal dollars. Enhanced FMAP funding continued through April 2023. Washington invested most of the additional federal match funds back into Medicaid rates, increasing the daily rate provided to some LTC facility types. Many providers used these funds to pay staff at temporary emergency rates, which helped reduce turnover during a period of extreme uncertainty. In future epidemic disease outbreaks, using emergency funds to supply hazard pay, in acknowledgment of staff risk, may again help to reduce turnover and keep facilities staffed to a level at which they can quickly implement recommended infection control measures.

Washington distributed more than 269 million pieces of PPE from the state stockpile between March 2020 and October 2021, including 35 million respirator masks, 147 million gloves, and 8 million gowns. This support will be critical in future public health emergencies. We recommend creating a streamlined process for access to governmental stocks of PPE through emergency management because the process varies by county and is not always intuitive. Disease variants, like we experienced during the COVID-19 pandemic, may create waves and surges causing LTC facilities and others to need additional PPE support. State and local emergency management should be aware of these possibilities and avoid completely ending governmental support while a public health emergency continues. We also recommend the Legislature consider measures to more quickly initiate or re-initiate standup of governmental stockpiles.

During the development of the interim report, workgroup participants identified challenges to accessing COVID-19 testing resources. Testing was largely unavailable early in the pandemic, and many LTC facility types needed external support from LHJs and community testing resources. LTC facilities found it difficult to establish cohorting processes necessary for infection

prevention and control without access to rapid and accurate testing. The swift production and distribution of rapid tests will be critical to early outbreak identification in future epidemic scenarios. State and local emergency management should prioritize LTC for testing support and supply distribution.

Coordination

Difficulty with public health guidance and coordination of care were other themes brought forward by the workgroup. LTC providers and LHJs often have limited interactions with each other, if any at all, so both sides have a lot to learn about each other. COVID-19 brought an onslaught of rapidly changing guidance as we all learned about the virus. Building knowledge, relationships, and communication are vital to improving coordination of infectious disease prevention and control.

Workgroup participants discussed the following needs related to coordinating a public health and LTC response during an outbreak or pandemic:

- Clear guidance that considers the Continuing Care Retirement Community (CCRC) model. CCRCs need more clarity and support to apply guidance across facilities with different levels of care within the community. Restrictions or recommendations may differ at each level of care.
- Visitation policies that consider resident mental health. Development of and exceptions to visitation guidance that allow for social interaction, physical activity, and access to family and others significant to the resident's mental health and well-being.
- Specific system planning for adult family homes. There are approximately 4,000 adult family homes across Washington. As individual small businesses, they are often isolated and may have difficulty accessing resources for emergency preparedness.
- Systematic approaches for using advance directives to coordinate health care in a manner and location the resident and family want.
- More clarity and better tracking of regulatory waivers. The state waived some regulations in RCW or WAC during the pandemic to support health care in the new COVID-19 environment. Some participants thought these waivers were useful, but difficult to track.
- Consistent discharge planning practices to improve the ongoing well-being and safety of residents. Discharge problems were present before the pandemic for residents with chronic or serious mental illness, individuals with dementia, residents with short-term skilled nursing stays who were previously unhoused, and others.
- Strong relationships across sectors for information sharing and guidance clarification. LTC facilities with established relationships with state- and county-level authorities and LHJs with established relationships with state agencies better understood who to call for

answers and information early in the pandemic. Having these relationships in place before an emergency arises is critical for effective communication during a crisis.

- A streamlined plan for communication and guidance-conflict resolution to clarify regulatory discrepancies. DOH hosted weekly LTC Q&A calls with panelists from DSHS, LTC associations, LHJs, and others to give LTC providers an opportunity to ask clarifying questions about guidance and receive advice. Participants report these calls have been helpful.

In February 2022, DSHS transitioned from its COVID-specific Safe Start guidance to a Long-Term Care COVID Response Plan. The new plan recommends LTC providers follow CDC, DOH, and (if applicable) CMS guidance and links to the appropriate guidance from these authorities. This change will make it easier for LTC providers to understand which guidance applies to their facility type.

Workgroup participants reported not having a clear understanding of who to contact to get guidance clarification, and 60 percent of survey respondents had to wait more than three days to receive clarity or resolution to their question about seemingly conflicting guidance. A clear communication plan or pathway for guidance conflict resolution will be important to providers in future public health emergencies.

One possible pathway could be the addition of a Guidance Conflict Rapid-Response Team to the larger response structure during a public health emergency. When a provider has concerns about regulatory or guidance language that appears contradictory, the rapid-response team could consult directly with the provider who shared the concern, ideally within 72 hours. Team composition could include representatives from:

- DOH Licensing and Certification, Disease Control and Health Statistics Office of Communicable Disease Epidemiology, or Science Officer or designee.
- DSHS – Licensing and Certification.
- Local Health Jurisdiction (LHJ) Medical Director or designee.
- Governor's Office designee when the issue concerns the details of a proclamation.
- State Emergency Management Division designee as needed, depending on emergency response communication structure in place.
- Department of Labor and Industries (if the issue affects worker health issues).
- Other subject matter experts, as needed.

This would give providers a way to report any potential conflict to DOH and DSHS. The team would assess and triage concerns with priority given to those that present work-stoppages. The Rapid-Response Team would also address concerns that potentially involve multiple agencies or multiple providers and have regional implications. When resolved, affected agencies could communicate the concern and response to all providers through existing communication methods.

Ways to Consistently Apply Epidemic Preparedness and Response Guidelines Across Washington

We encourage all LHJs and LTC facilities in Washington to be familiar with and use the epidemic preparedness and response guidelines developed because of SHB 1218 section 30.

There are strong similarities in planning for traditional emergencies (earthquakes, floods, wildfires, and so on) and planning for a public health emergency (epidemic or pandemic). Although the events may differ, the response to each is based on a core set of principles. Both response types use assessments, communications, policy, and procedure; and require teaching, training, and testing of the plan. Relationship-building in advance of the crisis is necessary to both processes. The COVID-19 pandemic has shown preparations must include the possibility of co-occurring events. Hurricanes, large-scale wildfires, floods, and tornados have all occurred during the pandemic, adding even greater demands to already challenging situations. Using an emergency response plan as the foundation of an epidemic response plan supports a stronger response when dealing with simultaneous events. The longer a public health emergency persists, the more likely it is a co-occurring natural disaster will compound the situation.

Statewide support and connection to resources are necessary for consistent application of epidemic preparedness and response guidelines across LTC facilities in Washington. Many emergency preparedness resources exist that can be adapted for epidemic preparedness in a variety of LTC facility types. DSHS and DOH will build on existing relationships with emergency preparedness subject matter experts and draw on the expertise of the LTC community. Many LTC facilities in Washington already engage in emergency preparedness work specific to their setting. Facilities that have more preparedness experience may find these adapted resources can supplement their existing plans. Facilities new to epidemic preparedness may use these resources to implement pieces of the guidelines that are relevant to their settings.

Emerging Epidemics of Public Health Concern

An emerging epidemic of public health concern is an epidemic or outbreak of a pathogen with the potential to cause increased illness and death. Long-term care providers should be aware of emerging epidemics. Awareness of emerging epidemics gives providers time to learn the symptoms, plan any necessary precautions, and train staff.

Monkeypox

An outbreak of monkeypox virus (MPV) began in the United States during May 2022. It does not commonly occur here. The current outbreak in Washington state is part of the larger national and global outbreak. You can find more information about MPV on the DOH website and the CDC website.

MPV can spread to anyone. Person-to-person spread happens through close, personal contact, often skin-to-skin contact. Close, personal contact includes:

- Direct contact with monkeypox rash, scabs, or body fluids from a person with MPV.
- Touching objects, fabrics (clothing, bedding, or towels), and surfaces used by someone with MPV.
- Contact with respiratory secretions.

DOH, DSHS, and LTC providers set-up regular calls to begin information sharing and infection prevention early. On August 23, 2022, DOH and DSHS also sent a Dear Provider letter to all LTC facilities with updates about what to look for, when to report, and how to report. The letter gives setting specific instructions. In September 2022, a facility reported one case in a staff member. So far, there are no reported cases of MPV in a LTC resident.

Polio

Poliovirus is a rare and serious pathogen that causes significant illness. On September 9, 2022, the State of New York declared a State Disaster Emergency for poliovirus. New York identified one case of vaccine-derived paralytic polio in a state resident who had no recent international travel, and poliovirus in wastewater samples from three counties. As of September 2022, New York has not found any more cases of poliovirus.

Washington has not found any cases of poliovirus.

Updates to the Guidelines

DOH and DSHS made a plain talk version of the guidelines. LTC providers come from a variety of backgrounds, and many do not have formal health care training beyond basic certification requirements. We want LTC providers of all types to feel they can learn and implement epidemic preparedness. The plain talk version features definitions, tips, more accessible language, and graphics. We did not change the content or recommendations.

Conclusion

The LTC community faced significant challenges during the COVID-19 pandemic. DOH and DSHS worked with LTC community members to understand barriers and challenges, and to identify lessons learned, best practices, and future needs. This learning will be ongoing as the pandemic continues to evolve.

DOH and DSHS will continue to work with LTC community members to update the epidemic disease preparedness and response guidelines developed because of SHB 1218. Through this collaboration we will support LTC preparedness for future epidemics, resulting in improved health, safety, and quality of life for all members of the LTC community.

Appendices

Appendix A. List of SHB 1218 Workgroup Members

Christa Arguinchona, Providence Sacred Heart Medical Center
Sandra Assasnik, Washington State Hospital Association
Heidi Audette, Department of Veterans Affairs
Doris Barret, Developmental Disabilities Administration
Sharla Bode, Washington Home Care Association
Carolyn Cartwright, REDi Healthcare Coalition
Harp Cheema, Whatcom County Health Department
Kim Conner, Washington State Independent Living Council
Karen Cordero, Adult Family Home Council
Robin Dale, Washington Health Care Association
Julietta Davidson, Developmental Disabilities Administration
Leslie Emerick, Washington State Hospice & Palliative Care Organization
Linda Fairbank, Department of Veterans Affairs
John Ficker, Adult Family Home Council
Brad Forbes, Alzheimer's Association
Amy Freeman, LTC Ombuds
Alan Frey, Kitsap Home Care Services
Donna Goodwin, Home Care Association of WA
Amal Grabinski, Provail Supported Living
Peter Graham, DSHS Aging and Long-term Support Administration
Saif Hakim, Developmental Disabilities Administration
Kelly Hampton, Developmental Disabilities Administration
Barb Hansen, Washington State Hospice & Palliative Care Organization
Chad Higman, Puget Sound Regional Services
Laura Hofmann, LeadingAge WA
Todd Holloway, Center for Independence
Patricia Hunter, LTC Ombuds
Angeles Ize, Benton-Franklin Health District
Jacqueline Kinley, Unified Care Systems
James Lewis, Public Health Seattle-King County
Larissa Lewis, WA DOH
Scott Livengood, Alpha Supported Living
Danielle Love, Whatcom County Health Department
Cathy Maccaul, AARP
Elena Madrid, Washington Health Care Association
Barbara McMullen, State Fire Marshal's Office

Vicki McNealley, Washington Health Care Association
Dylan Montgomery, State Fire Marshal's Office
Deb Murphy, LeadingAge WA
Dana Nguyen, Clark County Public Health
Travis Nichols, WA DOH
Jeremy Norden-Paul, Washington State Developmental Disabilities Council
Alyssa Odegaard, LeadingAge WA
Susan Pelaez, Northwest Healthcare Response Network
Sara Podczervinski, WA DOH
Cassie Prather, Spokane Regional Health District
Drew Pratt, Spokane Regional Health District
Sabine Preyss, Washington Society for Post-Acute and Long-Term Care Medicine
Aaron Resnick, Northwest Healthcare Response Network
Lisa Robbe, Developmental Disability Ombuds
Betty Schwieterman, Developmental Disability Ombuds
Katherine Seibel, National Alliance on Mental Illness
Noah Seidel, Developmental Disability Ombuds
Brianna Smith, Comagine Health
Melanie Smith, LTC Ombuds
Lauri St. Ours, Washington Health Care Association
Christina Wells, Developmental Disabilities Administration
Annette, LTC resident
Judah, Resident family member
Julia, LTC resident
Katrina, Resident family member
Randi, LTC resident
Susan, LTC resident

Appendix B. Workgroup Comment on the July 2022 Report

Comment from Leading Age, received September 20, 2022:

> Overall, the guidelines did not meet our expectations because they did not address the significant and ongoing challenges inherent in the lack of coordination between state agencies and local health jurisdictions charged with pandemic management. Instead, the guidelines focus solely on the long-term care providers, not the entire system. We have made recommendations to update the guidelines to better meet the intent in the annual update.
>
> We believe the guidelines can be a helpful tool for providers to help make their preparedness plans, but if they are going to be successful more needs to be included on establishing better situational awareness of infectious agents and how to prevent or mitigate spread, understanding which agency or agencies are the lead authority, where to send a request for supplies and staffing, how to obtain immediate support for patient discharge/relocation when resources are exhausted, or systems break down, and more.


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